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7
8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. *2013-350*
13 **ACCUSATION**

14 **BRANDON NEILL BILLINGS**
802 Debut Court
15 San Jose, CA 95134

16 **Registered Nurse License No. 627149**

Respondent.

17 Complainant alleges:

18 **PARTIES**

19 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
20 official capacity as the Executive Officer of the Board of Registered Nursing, Department of
21 Consumer Affairs.

22 2. On or about September 29, 2003, the Board of Registered Nursing issued Registered
23 Nurse License Number 627149 to Brandon Neill Billings (Respondent). The Registered Nurse
24 License was in full force and effect at all times relevant to the charges brought herein and will
25 expire on March 31, 2013, unless renewed.

26 **JURISDICTION**

27 3. This Accusation is brought before the Board of Registered Nursing (Board),
28 Department of Consumer Affairs, under the authority of the following laws. All section

1 references are to the Business and Professions Code unless otherwise indicated.

2 4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent
3 part, that the Board may discipline any licensee, including a licensee holding a temporary or an
4 inactive license, for any reason provided in Article 3 (commencing with section 2750) of the
5 Nursing Practice Act.

6 5. Section 2761 of the Code states:

7 "The board may take disciplinary action against a certified or licensed nurse or deny an
8 application for a certificate or license for any of the following:

9 "(a) Unprofessional conduct, which includes, but is not limited to, the following:

10 "(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing
11 functions.

12 ..."

13 6. Section 2762 of the Code states:

14 "In addition to other acts constituting unprofessional conduct within the meaning of this
15 chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this
16 chapter to do any of the following:

17 "(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed
18 physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or
19 administer to another, any controlled substance as defined in Division 10 (commencing with
20 Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as
21 defined in Section 4022.

22 "(b) Use any controlled substance as defined in Division 10 (commencing with Section
23 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in
24 Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to
25 himself or herself, any other person, or the public or to the extent that such use impairs his or her
26 ability to conduct with safety to the public the practice authorized by his or her license.

27 "(c) Be convicted of a criminal offense involving the prescription, consumption, or
28 self-administration of any of the substances described in subdivisions (a) and (b) of this section,

1 or the possession of, or falsification of a record pertaining to, the substances described in
2 subdivision (a) of this section, in which event the record of the conviction is conclusive evidence
3 thereof.

4 "(d) Be committed or confined by a court of competent jurisdiction for intemperate use of
5 or addiction to the use of any of the substances described in subdivisions (a) and (b) of this
6 section, in which event the court order of commitment or confinement is prima facie evidence of
7 such commitment or confinement.

8 "(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any
9 hospital, patient, or other record pertaining to the substances described in subdivision (a) of this
10 section."

11 7. California Code of Regulations, title 16, section 1442, states:

12 "As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from
13 the standard of care which, under similar circumstances, would have ordinarily been exercised by
14 a competent registered nurse. Such an extreme departure means the repeated failure to provide
15 nursing care as required or failure to provide care or to exercise ordinary precaution in a single
16 situation which the nurse knew, or should have known, could have jeopardized the client's health
17 or life."

18 8. California Code of Regulations, title 16, section 1443, states:

19 "As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the
20 failure to exercise that degree of learning, skill, care and experience ordinarily possessed and
21 exercised by a competent registered nurse as described in Section 1443.5."

22 9. Health and Safety Code section 11173(a) states, in pertinent part, that no person shall
23 obtain or attempt to obtain controlled substances, or procure or attempt to procure the
24 administration of or prescription for controlled substances by fraud, deceit, misrepresentation or
25 subterfuge.

26 10. Code section 4060 provides, in pertinent part, that no person shall possess any
27 controlled substance, except that furnished upon a valid prescription/drug order.
28

11. Health and Safety Code section 11377, in pertinent part, makes it unlawful to possess any controlled substance in Schedule II, subdivision (d), without a prescription.

12. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

13. Section 118, subdivision (b), of the Code provides that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

14. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

15. Diazepam, also known as Valium, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(9) and a dangerous drug as designated by Business and Professions Code section 4022. It is a depressant drug.

16. Dilaudid is a brand of hydromorphone hydrochloride, a Schedule II controlled substance as designated by Health and Safety Code section 11055(b) and a dangerous drug as designated by Business and Professions Code section 4022, used for pain relief.

17. Ketamine is a Schedule III controlled substance as listed in Health and Safety Code section 11056(g) and is a dangerous drug pursuant to section 4022 of the Business and Professions Code. It is used in general anesthesia.

18. Lorazepam, also known as Ativan, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(16) and is a dangerous drug per Code section 4022. It is a benzodiazepine, muscle relaxant and anti-convulsant.

19. Morphine is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(L), and a dangerous drug as designated by Business and Professions Code section 4022. It is used to treat moderate to severe pain.

20. Versed is a brand of midazolam, a Schedule II controlled substance as designated by Health and Safety Code section 11057(d)(21) and a dangerous drug as designated by Business and Professions Code section 4022. It is used to induce sleepiness or drowsiness and to relieve anxiety before surgery or other procedures.

FIRST CAUSE FOR DISCIPLINE

(UNINTELLIGIBLE ENTRIES IN PATIENT RECORDS)

21. Respondent is subject to disciplinary action under section 2762(e) in that while employed as a registered nurse at Santa Clara Valley Medical Center in Santa Clara, California, Respondent falsified, made grossly incorrect, grossly inconsistent, and/or unintelligible entries in hospital or patient records as follows:

22. Patient 1: On June 27, 2010 at 23:39 hours, the Emergency Department Physician ordered morphine 2.5 mg IV stat for Patient 1. At 00:56 on June 28, 2010, Respondent removed 5 mg of morphine from the hospital Pyxis.¹ Respondent immediately wasted 2.5 mg of the morphine. At 00:54 on June 28, 2010, Respondent documented in the nursing notes "medication refused by pt Morphine." Respondent failed to document administration or wastage of 2.5 mg of the morphine or otherwise account for its disposition.

23. Patient 2: On June 28, 2010 at 04:36, the Emergency Department Physician ordered morphine 0.1 mg/kg IV stat for Patient 2. Respondent correctly calculated the dose based on the patient's weight as 4 mg morphine. At 04:50, Respondent removed 5 mg of morphine from the Pyxis. Respondent documented administration of 4 mg morphine IV at 04:51. Respondent failed to document administration or wastage of 1 mg of morphine, or otherwise account for its disposition.

24. Patient 3: On June 28, 2010 at 05:50, the Emergency Department Physician ordered 5 mg of morphine for Patient 3. At 06:15, Respondent removed 5 mg of morphine from the Pyxis. Respondent failed to document administration or wastage of the morphine or otherwise account for its disposition.

¹ Pyxis is a computerized medication dispensing system.

1 25. Patient 4: Patient 4 was discharged from the Emergency Department on July 6, 2010
2 at 17:22. On July 6, 2010 at 18:14, Respondent removed 10 mg Diazepam from the Pyxis for
3 Patient 4. Respondent immediately wasted 5 mg of the Diazepam. Patient 4 did not have a
4 physician's order for Diazepam. Respondent failed to document administration or wastage of the
5 5 mg of Diazepam, or otherwise account for its disposition.

6 26. Patient 5: On July 7, 2010 the Emergency Department Physician ordered 2 mg
7 Dilaudid IV stat for Patient 5. Respondent removed 2 mg of Dilaudid from the Pyxis at 17:42.
8 Respondent failed to document administration of the Dilaudid for 31 minutes.

9 27. Patient 6: On July 15, 2010 at 21:20 the Emergency Department Physician ordered 1
10 mg Lorazepam IV stat for Patient 6, and Respondent noted the physician's order at 21:42.
11 Respondent removed 2 mg of Lorazepam from the Pyxis at 20:54, 48 minutes prior to
12 documentation of the physician's order. Respondent administered 1 mg Lorazepam at 21:51, 57
13 minutes after removing medication from the Pyxis. Respondent failed to document
14 administration or wastage of 1 mg of Lorazepam or otherwise account for its disposition.

15 28. Patient 7: On July 23, 2010 at 18:56 the Emergency Department Physician ordered
16 Ketamine 2 mg/kg IV for Patient 7. The patient was undergoing a procedure that required
17 sedation. The procedure started at 19:20, was completed by 19:54, and the patient was
18 discharged from the Emergency Department at 20:41. At 20:50 Respondent removed 500 mg
19 Ketamine from the Pyxis for this patient, 90 minutes after the medication had already been
20 administered, and 9 minutes after the patient had been discharged from the Emergency
21 Department.

22 29. Patient 8: On August 2, 2010 at 04:02 the Emergency Physician ordered Dilaudid 1
23 mg stat for Patient 8. At 04:17, Respondent removed 2 mg Dilaudid from the Pyxis and
24 immediately wasted 1 mg. At 04:15 Respondent documented that he administered 1 mg
25 Dilaudid. However, at 05:48, under the same patient name, Respondent wasted another 1 mg
26 Dilaudid which indicated the patient did not receive any of the Dilaudid that Respondent removed
27 from the Pyxis. The second wastage was over 90 minutes after Respondent withdrew the
28 medication from the Pyxis.

30. Patient 9: On August 7, 2010 at 05:32 the Emergency Department Physician ordered Versed 7 mg IV stat for Patient 9. The patient was intubated as a result of a drug overdose and was becoming agitated while on a ventilator. At 05:42 Respondent removed 6 mg Versed from the Pyxis and documented the administration of 6 mg Versed at 05:40. Respondent did not have a physician's order to change the order from Versed 7 mg to Versed 6 mg.

31. Patient 10: On August 8, 2010 at 05:02 the Emergency Department Physician ordered morphine 10 mg IV stat for Patient 10. At 05:22 Respondent removed 10 mg of morphine IV for Patient 10 and at 05:15 Respondent documented administration of morphine 5 mg IV, seven minutes prior to its withdrawal. Respondent failed to document administration or wastage of the remaining morphine or otherwise account for its disposition.

32. Patient 11: On August 8, 2010 at 23:27 the Emergency Department Physician ordered Lorazepam .5 mg IV stat for Patient 11. At 23:35 Respondent removed 2 mg of Lorazepam from the Pyxis for Patient 11. At 23:55 Respondent documented administration of Lorazepam .5 mg IV. Respondent failed to document administration or wastage of the remaining Lorazepam, or otherwise account for its disposition.

33. At 23:46 the Emergency Department Physician ordered Dilaudid 1 mg IV stat for Patient 11. Respondent removed 2 mg of Dilaudid from the Pyxis for Patient 11. At 23:53 Respondent documented that he administered 1 mg Dilaudid to the patient. Respondent failed to document administration or wastage of the remaining Dilaudid, or otherwise account for its disposition.

SECOND CAUSE FOR DISCIPLINE

(GROSS NEGLIGENCE)

34. Respondent is subject to disciplinary action under section 2761(a)(1) in that he was grossly negligent as alleged above in paragraphs 22 to 33.

THIRD CAUSE FOR DISCIPLINE

(INCOMPETENCE)

35. Respondent is subject to disciplinary action under section 2761(a)(1) in that he was incompetent as alleged above in paragraphs 22 to 33.

1 FOURTH CAUSE FOR DISCIPLINE

2 (ILLEGALLY OBTAIN OR POSSESS CONTROLLED SUBSTANCES)

3 36. Respondent is subject to disciplinary action under Code sections 2762(a) and 4060,
4 Health and Safety Code section 11173(a), and Health and Safety Code section 11377 in
5 Respondent illegally obtained and/or possessed controlled substances as alleged above in
6 paragraphs 22 to 29 and 31 to 33.

7 FIFTH CAUSE FOR DISCIPLINE

8 (UNPROFESSIONAL CONDUCT)

9 37. Respondent is subject to disciplinary action under section 2761(a) in that he acted
10 unprofessionally as alleged above in paragraphs 22 to 33.

11 PRAYER

12 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
13 and that following the hearing, the Board of Registered Nursing issue a decision:

14 1. Revoking or suspending Registered Nurse License Number 627149, issued to
15 Brandon Neill Billings;

16 2. Ordering Brandon Neill Billings to pay the Board of Registered Nursing the
17 reasonable costs of the investigation and enforcement of this case, pursuant to Business and
18 Professions Code section 125.3;

19 3. Taking such other and further action as deemed necessary and proper.
20
21

22 DATED: November 1, 2012

23 *for* Louise R. Bailey
24 LOUISE R. BAILEY, M.ED., RN
25 Executive Officer
26 Board of Registered Nursing
27 Department of Consumer Affairs
28 State of California
Complainant

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